

**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

**In the Matter of the Accusation
Against:**

David Huang Kwa Su, M.D.

Case No. 800-2017-029757

**Physician's and Surgeon's
Certificate No. G 59360**

Respondent

DECISION

**The attached Stipulated Surrender of License and Order is hereby
adopted as the Decision and Order of the Medical Board of California,
Department of Consumer Affairs, State of California.**

This Decision shall become effective at 5:00 p.m. on September 13, 2018.

IT IS SO ORDERED September 6, 2018

MEDICAL BOARD OF CALIFORNIA

By:


**Kimberly Kirchmeyer
Executive Director**

1 XAVIER BECERRA
Attorney General of California
2 E. A. JONES III
Supervising Deputy Attorney General
3 CLAUDIA RAMIREZ
Deputy Attorney General
4 State Bar No. 205340
California Department of Justice
5 300 South Spring Street, Suite 1702
Los Angeles, CA 90013
6 Telephone: (213) 269-6482
Facsimile: (213) 897-9395
7 *Attorneys for Complainant*

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 DAVID HUANG KWA SU, M.D.
14 4626 El Rito Drive
Orange, California 92867

15 Physician's and Surgeon's Certificate
16 No. G 59360,

17 Respondent.

Case Nos. 800-2017-029757; 800-2015-014356

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

18
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
20 entitled proceedings that the following matters are true:

21 **PARTIES**

22 1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical
23 Board of California ("Board"). She brought this action solely in her official capacity and is
24 represented in this matter by Xavier Becerra, Attorney General of the State of California, by
25 Claudia Ramirez, Deputy Attorney General.

26 2. David Huang Kwa Su, M.D. ("Respondent") is represented in this proceeding by
27 attorney Raymond J. McMahon, whose address is 5440 Trabuco Road, Irvine, California,
28 92620.

1 800-2017-029757, if proven at a hearing, constitute cause for imposing discipline upon his
2 Physician's and Surgeon's Certificate.

3 10. For the purpose of resolving the Accusation without the expense and uncertainty of
4 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima
5 facie case for the charges in Accusation No. 800-2017-029757 and that those charges constitute
6 cause for discipline. Respondent hereby gives up his right to contest that cause for discipline
7 exists based on those charges.

8 11. Respondent agrees that if he ever petitions for reinstatement of his Physician's and
9 Surgeon's Certificate No. G 59360, all of the charges and allegations contained in Accusation
10 Nos. 800-2017-029757 and 800-2015-014356 shall be deemed true, correct and fully admitted by
11 Respondent for purposes of that reinstatement proceeding or any other licensing proceeding
12 involving Respondent in the State of California.

13 12. Respondent understands that by signing this stipulation he enables the Board to issue
14 an order accepting the surrender of his Physician's and Surgeon's Certificate without further
15 process.

16 CONTINGENCY

17 13. This stipulation shall be subject to approval by the Board. Respondent understands
18 and agrees that counsel for Complainant and the staff of the Board may communicate directly
19 with the Board regarding this stipulation and surrender, without notice to or participation by
20 Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he
21 may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board
22 considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order,
23 the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this
24 paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not
25 be disqualified from further action by having considered this matter.

26 14. The parties understand and agree that Portable Document Format (PDF) and facsimile
27 copies of this Stipulated Surrender of License and Order, including Portable Document Format
28 (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 59360, issued to Respondent David Huang Kwa Su, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation Nos. 800-2017-029757 and 800-2015-014356 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.


5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation Nos. 800-2017-029757 and 800-2015-014356 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully


1 discussed it with my attorney, Raymond J. McMahon, Esq. I understand the stipulation and the
2 effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated
3 Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound
4 by the Decision and Order of the Medical Board of California.

5
6
7 DATED: 8/25/2018


DAVID HUANG KWA SU, M.D.
Respondent

9 I have read and fully discussed with Respondent David Huang Kwa Su, M.D. the terms and
10 conditions and other matters contained in this Stipulated Surrender of License and Order. I
11 approve its form and content.

12
13
14 DATED: August 27, 2018


RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent


15
16
17 ENDORSEMENT

18 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
19 for consideration by the Medical Board of California of the Department of Consumer Affairs.

20 Dated: 8/27/18

Respectfully submitted,

21 XAVIER BECERRA
22 Attorney General of California
23 E. A. JONES III
Supervising Deputy Attorney General

24 
25 CLAUDIA RAMIREZ
26 Deputy Attorney General
27 Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-029757

1 XAVIER BECERRA
2 Attorney General of California
3 E. A. JONES III
4 Supervising Deputy Attorney General
5 CLAUDIA RAMIREZ
6 Deputy Attorney General
7 State Bar No. 205340
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9 300 South Spring Street, Suite 1702
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11 Telephone: (213) 269-6482
12 Facsimile: (213) 897-9395
13 *Attorneys for Complainant*

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO *Quinn H2018*
BY *Quinn* ANALYST

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

Case No. 800-2017-029757

David Huang Kwa Su, M.D.
4626 El Rito Drive
Orange, California 92867

A C C U S A T I O N

Physician's and Surgeon's Certificate
No. G 59360,

Respondent.

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about December 22, 1986, the Board issued Physician's and Surgeon's Certificate Number G 59360 to David Huang Kwa Su, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2020, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise

1 indicated.

2 4. Section 2227 of the Code provides that a licensee who is found guilty under the
3 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed
4 one year, placed on probation and required to pay the costs of probation monitoring, or such other
5 action taken in relation to discipline as the Board deems proper.

6 5. Section 2234 of the Code states:

7 "The board shall take action against any licensee who is charged with unprofessional
8 conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not
9 limited to, the following:

10 "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
11 violation of, or conspiring to violate any provision of this chapter.

12 "(b) Gross negligence.

13 "(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or
14 omissions. An initial negligent act or omission followed by a separate and distinct departure from
15 the applicable standard of care shall constitute repeated negligent acts.

16 "(1) An initial negligent diagnosis followed by an act or omission medically appropriate for
17 that negligent diagnosis of the patient shall constitute a single negligent act.

18 "(2) When the standard of care requires a change in the diagnosis, act, or omission that
19 constitutes the negligent act described in paragraph (1), including, but not limited to, a
20 reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the
21 applicable standard of care, each departure constitutes a separate and distinct breach of the
22 standard of care.

23 "(d) Incompetence.

24 "(e) The commission of any act involving dishonesty or corruption which is substantially
25 related to the qualifications, functions, or duties of a physician and surgeon.

26 "(f) Any action or conduct which would have warranted the denial of a certificate.

27 "(g) The practice of medicine from this state into another state or country without meeting
28 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not

1 apply to this subdivision. This subdivision shall become operative upon the implementation of the
2 proposed registration program described in Section 2052.5.

3 “(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and
4 participate in an interview by the board. This subdivision shall only apply to a certificate holder
5 who is the subject of an investigation by the board.”

6 6. Section 2266 of the Code states:

7 “The failure of a physician and surgeon to maintain adequate and accurate records relating
8 to the provision of services to their patients constitutes unprofessional conduct.”

9 **FIRST CAUSE FOR DISCIPLINE**

10 **(Gross Negligence-Patients 1 and 2)**

11 7. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),
12 in that he was grossly negligent in the care and treatment of Patients 1 and 2.¹ The circumstances
13 are as follows:

14 **Patient 1**

15 8. On or about October 7, 2016, Respondent began providing prenatal care to Patient 1,
16 a then thirty-year-old female who was approximately thirty-three to thirty-four weeks pregnant.
17 He annotated each visit with “U/S” next to the date of each visit, which indicates he did an in-
18 office ultrasound. Respondent did not note several fundamental anatomic features such as fetal
19 presentation, heart rate, amniotic fluid volume, placental location, biometric measurements, or
20 calculated fetal weight estimate as specified by the American Institute of Ultrasound in Medicine.

21 9. On or about November 26, 2016, at approximately 10:59 a.m., Patient 1 was admitted
22 to the hospital’s Labor and Delivery unit for delivery of her baby. She had spontaneous rupture
23 of membranes with lightly-stained (meconium-stained) amniotic fluid. She was not in active
24 labor.

25 10. At approximately 3:00 p.m., Patient 1’s cervix was dilated 1 cm, 50 percent effaced,
26 with the fetal vertex at -3 station. Oxytocin augmentation was initiated.

27 11. By approximately 6:00 p.m., Patient 1’s cervix was dilated 4 cm, completely effaced,

28 ¹ The names of patients are not used in order to protect their right to privacy.

1 and the fetal vertex had descended to 0 station.

2 12. At approximately 7:13 p.m., Respondent was called for delivery. He arrived at
3 Patient 1's bedside by 7:48 p.m.

4 13. By approximately 8:00 p.m., Patient 1's cervix was dilated 8 cm. At approximately
5 8:36 p.m., Respondent returned to, or remained at, Patient 1's bedside.

6 14. At approximately 8:39 p.m., Respondent applied the Kiwi vacuum. He applied it
7 before the cervix was completely dilated, the bladder had been emptied, and support personnel
8 were in the delivery room.

9 15. On or about November 27, 2016, at approximately 12:24 a.m., Patient 1 reached
10 complete cervical dilation. After nearly 2 hours of pushing by Patient 1, Respondent performed a
11 vacuum-assisted vaginal delivery. At approximately 2:14 a.m., at +1 station, Respondent applied
12 the Kiwi vacuum cup with Respondent pulling 5 times over the ensuing 60 seconds of application
13 time. At approximately 2:16 a.m., Respondent delivered the baby. Patient 1 had a first degree
14 vaginal laceration which Respondent repaired.

15 16. The following day, on or about November 28, 2016, Patient 1 was discharged from
16 the hospital. Respondent did not write a progress note on November 28, 2016 (postpartum day
17 number one), which reflects that he either did not see Patient 1 again or that he failed to document
18 that he evaluated her.

19 17. Two to three weeks following Patient 1's hospitalization, on or about December 14,
20 2016, Respondent dictated a late and incomplete History and Physical for Patient 1's hospital
21 admission of November 26, 2016. He also dictated a Discharge Summary.

22 18. Respondent committed grossly negligent acts with respect to the care and treatment of
23 Patient 1 as follows:

24 19. Respondent committed an extreme departure from the standard of care when, on or
25 about November 26, 2016, at approximately 8:30 p.m., he initially applied the vacuum in the
26 setting of an incompletely dilated cervix. It is a requisite that the cervix must be completely
27 dilated before vacuum application in all but the most extreme emergency situations. The medical
28 records, including electronic fetal monitor ("EFM") strips, do not reflect that such an

1 extraordinary emergency existed at the time to justify an emergent vacuum application.

2 Respondent did not document or consider requisite pre-application steps in preparing for the
3 vacuum-assisted delivery such as assessment of the maternal pelvis relative to fetal size, fetal
4 station, fetal position and presentation, adequate analgesia, dilation, and an empty bladder.

5 Patient 2

6 20. On or about August 9, 2016, Respondent began providing prenatal care to Patient 2, a
7 then twenty-four-year-old female who was approximately thirty-one to thirty-two weeks
8 pregnant. He annotated each subsequent visit with "U/S" next to the date, which indicates he did
9 an in-office ultrasound at each of her visits.

10 21. On or about October 12, 2016, Patient 2 was admitted to the hospital after
11 spontaneous rupture of the membranes at approximately 8:00 a.m. The fluid was clear. No
12 meconium-staining was noted.

13 22. At approximately 1:00 p.m., Patient 1 was transferred to the hospital's Labor and
14 Delivery unit for delivery of her baby.

15 23. By approximately 1 hour later, Patient 2's cervix was completely dilated, with the
16 fetal vertex at +2 station. At approximately 2:00 p.m., Respondent applied a vacuum. The
17 vacuum popped off. At approximately 2:01 p.m., the charge nurse requested clarification of the
18 indication for use of the vacuum. Respondent's documentation is absent regarding the indication
19 and pre-application assessment for a vacuum-assisted vaginal delivery.

20 24. Per Respondent's subsequently-dictated Operative Report for Cesarean section, he
21 described that after applying the vacuum and "a couple of pulls," he noted that the cervix was 8
22 cm dilated. Furthermore, with his pulling, the fetal heart rate decelerated. As a result,
23 Respondent took the vacuum off and planned for an emergent Cesarean section. However, the
24 fetal heart rate recovered. At approximately 2:43 p.m., the Cesarean section was done less
25 emergently, under spinal-epidural analgesia.

26 25. The Delivery Summary indicated that Respondent performed an emergent Cesarean
27 section for the listed indication of "Nonreassuring fetal status." According to Respondent, he had
28 difficulty in delivering the fetal vertex (head), after making the Cesarean uterine incision. As a

1 result, he utilized the vacuum.

2 26. The Delivery Summary indicates that the vacuum popped off (from the head) three
3 times, and the vacuum was applied for a total of 1 minute and 30 seconds. It is unclear whether
4 the three pop offs occurred during the attempt at vaginal delivery (at approximately 2:00 p.m.), or
5 at Cesarean section (at approximately 2:43 p.m.), or during a combination of both. The infant
6 was delivered at approximately 2:55 p.m. Patient 2's postoperative course was uncomplicated.

7 27. Three days after the Cesarean-section, on or about October 15, 2016, Patient 2 was
8 discharged from the hospital. Respondent did not write a progress note on October 13, 14, or 15,
9 2016, which reflects that he either did not see Patient 2 again or that he failed to document that he
10 evaluated her.

11 28. On or about November 9, 2016, Respondent dictated a Discharge Summary.

12 29. Respondent committed grossly negligent acts with respect to the care and treatment of
13 Patient 2 as follows:

14 30. Respondent committed an extreme departure from the standard of care when, on or
15 about October 12, 2016, at approximately 2:00 p.m., he initially applied the vacuum without an
16 indication and pre-application assessment. The standard of care requires, except in the utmost of
17 emergencies, full patient counseling and consent to include at least the indications, risks, and
18 options for operative vaginal delivery (forceps or vacuum). Pre-delivery assessment must include
19 assessment of the maternal pelvis relative to fetal size, fetal station (descent in the birth canal),
20 fetal position and presentation, adequate analgesia, complete cervical dilation, and an empty
21 bladder.

22 31. According to Respondent, he pulled a couple of times before removing the vacuum as
23 the cervix was 8 cm. This would suggest that either (1) he knowingly disregarded the requirement
24 for complete cervical dilation before applying the vacuum, or (2) he failed to accurately assess the
25 cervical dilation, as required by the standard of care, before applying the vacuum. The
26 descriptions, in the nursing notes, of the EFM patterns, throughout Patient 2's labor, did not
27 indicate a concern for an imminent threat to fetal well-being, per the nursing assessment, as a
28 justification for Respondent's omitting many of the requisite pre-application assessments and

1 patient counseling/consent in preparing for a vacuum-assisted vaginal delivery attempt.

2 Furthermore, Respondent did not document any such urgent concerns in the medical record. The
3 EFM tracings did not demonstrate an indication for operative vaginal delivery on a fetal basis.

4 32. Respondent's acts and/or omissions as set forth in paragraphs 8 through 31, inclusive
5 above, whether proven individually, jointly, or in any combination thereof, constitute gross
6 negligence pursuant to Code section 2234, subdivision (b). Therefore, cause for discipline exists.

7 **SECOND CAUSE FOR DISCIPLINE**

8 **(Repeated Negligent Acts-Patients 1, 2, 3, and 4)**

9 33. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),
10 in that he engaged in repeated negligent acts in the care and treatment of Patients 1, 2, 3, and 4.

11 The circumstances are as follows:

12 Patient 1

13 34. Respondent committed repeated negligent acts with respect to the care and treatment
14 of Patient 1 as follows:

15 35. The facts and allegations in paragraphs 8 through 19, above, are incorporated by
16 reference and re-alleged as if fully set forth herein.

17 36. Respondent's sparse documentation of Patient 1's prenatal care ultrasounds in her
18 medical record is a departure from the standard of care.

19 37. Respondent's lacking documentation regarding the vacuum applications on
20 November 26, 2016, at approximately 8:39 p.m., and November 27, 2016, at approximately 2:14
21 a.m., is a departure from the standard of care. The total application time, suction time, and
22 traction times should be recorded and documented as soon as possible after delivery. An
23 operative vaginal delivery should be documented by a detailed procedure note, which should
24 include, but is not limited to, the fetal station, cervical dilation, the instrument used, the amount of
25 rotation if any, duration of applications, and number of applications. Respondent failed to
26 document the indication for the instrumented mid-pelvic delivery at +1 station on November 27,
27 2016. That is considered a mid-pelvic delivery, which should be reserved for very unusual
28 circumstances, as the risks to both fetus and mother increase markedly with such higher stations

1 of application. Respondent did not identify the indication for the instrumented delivery in Patient
2 1's medical record.

3 38. Respondent's late and incomplete History and Physical for Patient 1's admission of
4 November 26, 2016, is a departure from the standard of care.

5 39. Respondent's lack of documentation of his inpatient postpartum care and/or
6 evaluation (if he rendered any) of Patient 1 is a departure from the standard of care.

7 Patient 2

8 40. Respondent committed repeated negligent acts with respect to the care and treatment
9 of Patient 2 as follows:

10 41. The facts and allegations in paragraphs 20 through 31, above, are incorporated by
11 reference and re-alleged as if fully set forth herein.

12 42. Respondent's lacking documentation regarding the vacuum applications at vacuum-
13 assisted vaginal delivery and Cesarean delivery is a departure from the standard of care.

14 43. Respondent's performing Patient 2's Cesarean section without a valid
15 medical/obstetric indication is a departure from the standard of care. The single prolonged fetal
16 heart rate deceleration did not, in the overall context of Patient 2's obstetric circumstances,
17 qualify as a valid indication for Cesarean section, particularly after the heart rate had recovered.
18 The Operative Note does indicate that the patient wanted an elective Cesarean section to avoid a
19 vaginal laceration and difficulties at vaginal delivery. According to Respondent, the patient kept
20 changing her mind on whether or not she wanted a Cesarean section. There is no record of a
21 patient-focused discussion of reassurance with the patient, or a specific discussion of risk and
22 benefits of surgery. The EFM do not suggest a legitimate concern for fetal well-being that would
23 excuse bypassing such a fundamental discussion before undertaking such a major surgical
24 procedure, nor would it comprise an indication for same.

25 44. Respondent's inaccurate and/or incomplete description of the Cesarean section and
26 pertinent procedural details is a departure from the standard of care. His Operative Report lacks
27 salient information, including but not limited to, the application of the vacuum, with difficulty in
28 delivering the fetal head. Instead, the Operative Report simply reads, "The baby delivered

1 without any complications.”

2 45. Respondent’s failure to daily evaluate Patient 2 during her inpatient postoperative
3 course for the three days following her surgery, or failure to document such evaluation, is a
4 departure from the standard of care.

5 Patient 3

6 46. On or about November 22, 2016, Respondent began providing prenatal care to Patient
7 3, a then twenty-four-year-old female who was approximately thirty-two weeks pregnant. Patient
8 3’s prenatal course and laboratory values were normal. Respondent used the ACOG Antepartum
9 Record template to document the prenatal care that he provided to her. His documentation on the
10 form was sparse, the form had missing information in several areas, and his handwriting was
11 borderline illegible. He did not document performing in-office ultrasounds or the standard
12 American Institute of Ultrasound in Medicine parameters.

13 47. On or about January 12, 2017, at approximately 12:41 a.m., Patient 3 was admitted to
14 the hospital’s Labor and Delivery unit for delivery of her baby. At approximately 8:42 a.m.,
15 Respondent used a vacuum to assist him with the delivery. The baby was born at approximately
16 8:48 a.m. Patient 3 suffered a third-degree vaginal laceration during the delivery, which
17 Respondent repaired. However, Respondent did not document the occurrence of the laceration,
18 the details of the repair, or technique of the repair. Respondent also did not inform Patient 3 of
19 the vaginal laceration. Patient 3 would not have known to take deliberate steps to avoid
20 constipation to allow for optimal healing.

21 48. Respondent’s handwritten delivery note, dated January 12, 2017, at approximately
22 9:00 a.m., is borderline legible. Respondent did not address the episiotomy, laceration, repair, or
23 recto-vaginal defect. He noted a vacuum-assisted vaginal delivery, but did not document the
24 details of the vacuum-assisted vaginal delivery, including, but not limited to, the indication,
25 counseling, consent, pre-delivery assessment, station, fetal position, total application time, suction
26 time, and traction time. Respondent noted there were no complications and that the estimated
27 blood loss was 200 ml. He noted Patient 3 gave birth to a female infant, whereas the nursing
28 documentation in at least two places shows Patient 3 gave birth to a male infant.

1 49. The next day, on or about January 13, 2017, at approximately 6:10 p.m., Patient 3
2 was discharged from the hospital. Respondent did not write a progress note on January 13, 2017
3 (postpartum day number one), which reflects that he either did not see Patient 3 again or that he
4 failed to document that he evaluated her. Respondent signed, but did not complete, an Obstetrical
5 Discharge Summary. He also did not date or time it.

6 50. On or about January 17, 2017, Respondent saw Patient 3 for postpartum care. On or
7 about January 21, 2017, Respondent saw Patient 3 again. She complained of feces in her vagina.
8 Patient 3 had a rectovaginal fistula.² On or about January 26, 2017, Respondent evaluated the
9 rectovaginal fistula. He subsequently scheduled her for an episiotomy repair, but Patient 3 did
10 not show up to the hospital or respond to Respondent's telephone calls.

11 51. Respondent committed repeated negligent acts with respect to the care and treatment
12 of Patient 3 as follows:

13 52. Respondent's inadequate documentation of Patient 3's prenatal care in her medical
14 record is a departure from the standard of care.

15 53. Respondent's lack of documentation regarding the details of his vacuum-assisted
16 vaginal delivery of Patient 3 is a departure from the standard of care.

17 54. Respondent's lack of documentation of his in-patient postpartum care and/or
18 evaluation (if he rendered any) of Patient 3 is a departure from the standard of care.

19 55. Respondent's failure to properly document the occurrence and repair of Patient 3's
20 third degree rectal sphincter injury is a departure from the standard of care.

21 56. Respondent's repair technique of Patient 3's third degree rectal sphincter injury is a
22 departure from the standard of care. The rectovaginal fistula occurred after Respondent repaired
23 the vaginal laceration. She had no underlying medical conditions that could otherwise explain the
24 occurrence of the rectovaginal fistula.

25 57. Respondent's estimate of Patient 3's obstetric blood loss is a departure from the
26 standard of care. Estimating blood loss is important in anticipating and preparing for postpartum

27 ² A rectovaginal fistula is an abnormal connection between the lower portion of the large
28 intestine (the rectum) and the vagina. Bowel contents can leak through the fistula, allowing gas
or stool to pass through the vagina.

1 hemorrhage, which is a leading cause of maternal morbidity. The average blood loss at vaginal
2 delivery is approximately 500 ml (500 cc). In addition, Patient 3's hematocrit dropped from 34.4
3 percent on admission to 22.9 percent the morning after delivery, which is a significant drop. Her
4 hemoglobin dropped correspondingly by 4 Gm/dL. The significant drop is consistent with and/or
5 highly suggestive of significant volume of interval blood loss. Respondent did not document
6 further significant ongoing excessive bleeding after delivery, which also suggests that the blood
7 loss at or around delivery was greater than Respondent's estimate.

8 Patient 4

9 58. On or about March 31, 2017, Respondent began providing prenatal care to Patient 4,
10 a then thirty-nine-year-old female who was approximately thirty-two weeks pregnant.

11 Respondent used the ACOG Antepartum Record template to document the prenatal care that he
12 provided to Patient 4. His documentation on the form was sparse, the form had missing
13 information in several areas, and his handwriting was borderline legible. Patient 4 appeared to
14 have an uncomplicated obstetric (prenatal-outpatient) course.

15 59. On or about May 26, 2017, at approximately 1:30 a.m., Patient 4 was admitted to the
16 hospital's Labor and Delivery unit for delivery of her baby.

17 60. Later that day, at approximately 8:00 p.m., Patient 4's cervix was completely dilated
18 (10 cm, 100% effaced, with the fetal head now at -1 station). Respondent was notified. He was
19 documented as being at the bedside at 8:50 p.m.

20 61. At approximately 9:09 p.m., Respondent delivered the baby.

21 62. Respondent's handwritten delivery note was timed and dated May 26, 2017, at
22 approximately 9:20 p.m. It was scant and cursory, lacking some critical information. The note
23 begins with, "Vacuum assisted vaginal delivery," yet provides none of the important salient
24 features and details that are required for the documentation of an operative vaginal delivery.
25 Furthermore, the delivery note fails to contain some basic elements including, but not limited to,
26 the baby's birthweight.

27 63. On or about May 27, 2017, Patient 4 was discharged from the hospital. Respondent
28 did not write a progress note on May 27, 2017 (postpartum day number one), which reflects that

1 he either did not see Patient 4 again or that he failed to document that he evaluated her.

2 64. Respondent committed repeated negligent acts with respect to the care and treatment
3 of Patient 4 as follows:

4 65. Respondent's sparse documentation of Patient 4's prenatal care in her medical record
5 is a departure from the standard of care as follows:

6 a. Except for listing the last menstrual period and due date, Respondent failed to
7 complete the Menstrual History and Expected Date of Delivery ("EDD") sections of the ACOG
8 Antepartum Record template. The areas for listing ultrasound findings, pregnancy test results, and
9 the menstrual history were left completely blank.

10 b. The Inpatient Pre-Anesthesia evaluation indicates that this was the patient's fifth
11 pregnancy with four prior Dilations and Curettages. However, Respondent's prenatal records
12 indicate that this was her first pregnancy, and makes no mention of four prior gynecologic
13 surgical procedures. Also, the Admission Assessment, authored by nursing personnel, indicates
14 that this is the patient's fifth pregnancy.

15 c. Respondent left blank the very top space (reflecting its utmost importance) on the
16 ACOG Antepartum Record Prenatal Flowsheet. That space is provided for the physician to list
17 the patient's allergies to medications. Patient 4's Labor and Delivery records and Anesthesia
18 records indicate that the patient was allergic to Penicillin. This oversight, regarding a
19 hypersensitivity reaction ("allergy") to a drug, by Respondent, or in his documentation, could
20 lead to severe morbidities or even mortality if not picked up by other medical personnel.

21 d. Respondent's documentation is overall barely legible.

22 66. Respondent's inadequate documentation of the operative vaginal delivery of Patient 4
23 is a departure from the standard of care. Specifically, he wrote, "Vacuum-assisted vaginal
24 delivery," but failed to address any important specific details required by the standard of care.

25 67. Respondent's lack of documentation of his inpatient postpartum care and/or
26 evaluation (if he rendered any) of Patient 4 is a departure from the standard of care.

27 68. Respondent's acts and/or omissions as set forth in paragraphs 34 through 67,
28 inclusive above, whether proven individually, jointly, or in any combination thereof, constitute

1 repeated negligent acts pursuant to Code section 2234, subdivision (c). Therefore, cause for
2 discipline exists.

3 **THIRD CAUSE FOR DISCIPLINE**

4 **(Inadequate and Inaccurate Recordkeeping-Patients 1, 2, 3, and 4)**

5 69. Respondent is subject to disciplinary action under Code section 2266 in that he
6 maintained inadequate and inaccurate medical records for Patients 1, 2, 3, and 4. The
7 circumstances are as follows:

8 70. The facts and allegations in paragraphs 8 through 67, above, are incorporated by
9 reference and re-alleged as if fully set forth herein.

10 71. Respondent's acts and/or omissions as set forth in paragraphs 8 through 67, inclusive
11 above, whether proven individually, jointly, or in any combination thereof, constitute inadequate
12 and inaccurate recordkeeping pursuant to Code section 2266. Therefore, cause for discipline
13 exists.

14 **FOURTH CAUSE FOR DISCIPLINE**

15 **(Unprofessional Conduct-Patients 1, 2, 3, and 4)**

16 72. Respondent is subject to disciplinary action under Code section 2234 in that he
17 engaged in unprofessional conduct with respect to the care and treatment of Patients 1, 2, 3, and
18 4. The circumstances are as follows:

19 73. The facts and allegations in paragraphs 8 through 71, above, are incorporated by
20 reference and re-alleged as if fully set forth herein.

21 74. Respondent's acts and/or omissions as set forth in paragraphs 8 through 71, inclusive
22 above, whether proven individually, jointly, or in any combination thereof, constitute
23 unprofessional conduct pursuant to Code section 2234. Therefore, cause for discipline exists.

24 **DISCIPLINARY CONSIDERATIONS**

25 75. To determine the degree of discipline, if any, to be imposed on Respondent,
26 Complainant alleges that, on or about May 18, 2018, in a prior disciplinary action entitled *In the*
27 *Matter of the Accusation Against David Huang Kwa Su, M.D.* before the Medical Board of
28 California, in Case Number 800-2015-014356, Respondent's license was revoked, the revocation

1 was stayed, and Respondent was placed on seven years' probation with various terms and
2 conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

3 **PRAYER**

4 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
5 and that following the hearing, the Medical Board of California issue a decision:


6 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 59360,
7 issued to Respondent David Huang Kwa Su, M.D.;

8 2. Revoking, suspending or denying approval of Respondent David Huang Kwa Su,
9 M.D.'s authority to supervise physician assistants and advanced practice nurses;

10 3. Ordering Respondent David Huang Kwa Su, M.D., if placed on probation, to pay the
11 Board the costs of probation monitoring; and

12 4. Taking such other and further action as deemed necessary and proper.

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14
15
16 DATED: August 14, 2018


KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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